

No. 300  
10-47  
17-59  
1-3906

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **10591**  
Registrar's No. **2697**

FILED MAR 25 1948

Registration District No. **318**

Primary Registration District No. **1005**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether  
In this community 27 Years  
years, months or days)

3. (a) PRINT FULL NAME Minnie Lee Rhodes

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race Col.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ruben Rhodes

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 6th 1899  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

48 8 9 hr. \_\_\_\_\_ min.

9. Birthplace Merdian Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Domestic

12. Name Lindsey Hood

13. Birthplace Mississippi  
(City, town, or county) (State or foreign country)

14. Maiden name Mary McDonald

15. Birthplace Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Ruben Rhodes  
(b) Address 1031, No. Leffenwell.

17. (a) Burial (b) Date thereof 3/20/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farther Dickson Cem.

18. (a) Signature of funeral director John H. Davidson

(b) Address 2800 Washington Blvd.

19. (a) MAR 18 1948 (b) J. F. BARNACK  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 1031 N Leffenwell  
21 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country U.S.A.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15  
year 1948 hour 1 minute 30 a. m.

21. I hereby certify that I attended the deceased from Mar. 13 1948 to Mar. 15 1948; that I last saw her alive on March 15 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Oscar J. Daniels (M. D. or other)  
Address 2601 N Whittier Date signed 3/17/48

Duration  
Undet.

PHYSICIAN  
Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Jeffrey E. Cooper*....., Registered Apprentice No. *505*  
working under my personal supervision.

Signed *James D. Byrd*  
Licensed Embalmer No. *4441*  
P. O. Address *2829 Washington*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Minnie & Rhodes

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: July (Month) 8 (Day) 1948 (Year)

8. AGE: 48 Years 8 Months 5 Days (Unless than one day, \_\_\_\_\_ min.)

9. Birthplace: \_\_\_\_\_ (City, town, or county) MISS (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 3-18-1948 (b) J.F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day \_\_\_\_\_ Year 1948 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. \_\_\_\_\_ Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

5-10-80